Marion CUSD #2 Request for Attendance Center Change
APPEAL

****Request is only active for the current school year. Applicant must reapply each year.**

Child's Name	Date of Birth	M F Gender

Child's Resident Parent's or Legal Guardian's Name	Child's Resident Parent's or Legal Guardian's Name

( )	( )	( )	( )
Home/Cell Phone	Work Phone	Home/Cell Phone	Work Phone

Address	City, ST ZIP Code
How many schools has this child already attended?	Please name the schools already attended.

Current Information

(To be completed by parent or legal guardian)

Child's CURRENT School	Child's CURRENT Grade Level
Child's CURRENT Classroom Teacher	Special Programs/Instruction my child CURRENTLY receives (For example: special education services)

Reason for Change of Attendance Center

(To be completed by a qualified personnel (medical doctor, psychiatrist, psychoanalyst, clinical psychologist. Physician Assistants DO NOT qualify for this purpose.)

Please give you **specific diagnosis** as it pertains to this child. Identify any physical or emotional problem and estimated duration, as well as, any prescribed medication.

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In what way will transfer to another school in Marion Community Unit #2 be detrimental to the child?

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How long have you been treating the child for this problem?

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Will this child be under your continuing care? If so, for what period of time?

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Additional comments:

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Signature of Qualified Person Completing This Form

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Title

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Telephone Number

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Date

**Decisions will be made approximately two weeks after receipt. Applying individual(s) listed above will be notified.

<u>For Office Use Only</u>

Date Received:	Time Received:	Received By:
Decision:	Date:	
Date Parent Notified:	☐ Phone	☐ Letter